NATIONAL LABOR RELATIONS BOARD
BEFORE HON. KIMBERLY R. SORG-GRAVES

CAYUGA MEDICAL CENTER
AT ITHACA, INC.

and

Cases 03-CA-185233
03-CA-186047

1199 SEIU UNITED HEALTHCARE
WORKERS EAST

CAYUGA MEDICAL CENTER'S
POST-HEARING BRIEF

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PRELIMINARY STATEMENT

The Respondent employer in the above-captioned cases, Cayuga Medical Center at Ithaca, Inc. ("CMC"), by and through its undersigned counsel, hereby submits this post-hearing brief in support of its position that the Amended Complaint should be dismissed in its entirety.

This case arises from CMC's termination of two Registered Nurses in the Intensive Care Unit ("ICU"), Anne Marshall and Loran Lamb. The undisputed evidence established that the two nurses knowingly and deliberately ignored the final most critical step in CMC's blood transfusion process (performing a two-nurse bedside verification), thus increasing the risk to the patient of a potential lethal outcome; and that they falsified the medical record by certifying that they had conducted the necessary bedside verification. When asked about the incident Ms. Lamb acknowledged that she failed to perform the final bedside check and never set foot in the patient's room, and that she knew it was wrong. Ms. Marshall admitted that she proceeded to violate the required safety protocol despite knowing the policy and despite the expressed concerns of a knowledgeable patient. Both nurses acknowledged certifying in the medical record that the two-nurse beside verification took place, even though it did not.

CMC only became aware of this incident because the patient herself decided to speak up and complain about the unsafe transfusion that she received at the hands of these nurses. CMC had a legal and ethical responsibility to follow up on the patient complaint, notwithstanding the fact that Ms. Marshall was a known union proponent who had previously been the subject of an unfair labor practice case against CMC. The purpose of the investigation was to ascertain the facts as to what occurred, regardless of the identity and/or union sentiments of the nurses involved. During the course of the investigation, Ms. Lamb and Ms. Marshall admitted that they knowingly violated CMC policy and that they entered false information in the medical record.

In explaining her behavior, Ms. Marshall initially contended that skipping the two-nurse bedside verification was common practice and thus asserted that something must be wrong with the policy and/or the education process for nurses since they were all purportedly getting it wrong. However, the overwhelming evidence established that Ms. Marshall's premise was not accurate. On the contrary, the information gathered during the investigation strongly indicated that other nurses were consistently performing the required two-nurse bedside verification. Furthermore, Ms. Marshall readily acknowledged certifying that she had recently reviewed the policy in CMC's computer-based training system. Ms. Marshall later shifted her explanation to blaming inadequate staffing and/or the busy conditions in the ICU at the time. However, this contention was also thoroughly refuted by the evidence obtained during the investigation, since the unit was not understaffed and none of the nurses sought assistance from the Charge Nurse who did not have a patient assignment, nor from the on-call nurse who was standing by if needed. Ms. Marshall later shifted again, ultimately declaring that performing the required two-nurse bedside verification was unnecessary in her opinion because she has the ability to multitask and to make such judgements despite policy and despite National Safety Standards. Finally, Ms. Marshall attempted to blame the Medical Center for targeting her due to her protected activity under the National Labor Relations Act, even though the genesis for the investigation was a patient complaint, rather than something initiated by management. None of this is in dispute, nor could it be because there is a recording of the above-described statements by Ms. Marshall.

There is a great deal of evidence in the record about the danger associated with blood product administration and the potential consequences of an error, including costing the patient his or her life, exposing the hospital to liability, draconian regulatory sanctions, severe reputational harm, and possible closure of the facility. There is also a great deal of evidence in the record about

the evolution of CMC's Blood Product Administration policy in the aftermath of a Near Miss incident in October 2012, as well as the evolution of a National Safety Standard for blood transfusions that CMC and all other hospitals in the United States are legally required to follow.

The proper delivery of acute care is serious business, particularly in an Intensive Care Unit where human lives hang in the balance. Knowingly and deliberately violating a critical patient safety standard during a high-risk medical procedure would be considered grossly unacceptable at any hospital in America. Likewise, deliberately falsifying a medical record is grossly unacceptable throughout the nursing profession and at CMC. Each of these offenses warrants immediate discharge, not to mention the combination of the two. None of the arguments advanced by the General Counsel or the Charging Party can trump the core facts of what happened here. CMC discharged these two nurses not <u>because</u> of union support, but <u>in spite</u> of that fact. The nurses were discharged due to their misconduct during the incident on September 11, 2016, which consisted of exhibiting a blatant disregard for patient safety, knowingly and deliberately violating CMC policy, and deliberately falsifying the medical record. These are the legitimate non-discriminatory reasons for their discharges, and these are the reasons why Respondent respectfully submits that the Amended Complaint in this case should be dismissed.[1]

[1] Throughout this brief, citations to the evidence in the record will appear as follows: "Tr. __" for page number references to the hearing transcript; "Ex. R-__" for references to Respondent's (or Employer's) Exhibits; "Ex. GC-__" for references to General Counsel's Exhibits; and "Ex. U-__" for references to the Union's (or Charging Party's) Exhibits. Unless otherwise noted all dates referred to are in 2016.

STATEMENT OF FACTS

Cayuga Medical Center is an acute care hospital that serves the healthcare needs of Ithaca, New York and the surrounding communities.

Blood product administration is a high-risk medical procedure because if the wrong blood is infused into a patient, the error can quickly result in an irreversible fatal reaction. (Tr. 1846-50, 3027, 3032).

Due to the high risk to the patient, and the fact that the typical work environment for nurses involves many responsibilities and frequent distractions, a series of safeguards have been developed to protect patients by minimizing the risk of errors. (Tr. 1846-50).

The most critical of these procedural safeguards is the requirement of a final two-nurse verification at the patient's bedside to ensure that the right blood is being administered to the right patient prior to starting the transfusion. (Tr. 1863-65, 3056). This consists of two nurses at the patient's bedside jointly confirming patient name and date of birth either verbally with the patient or by checking the patient's ID bracelet, and checking key information on the unit of blood, prior to hanging the blood. (Ex. GC-3).

This two-nurse bedside verification process for administering blood products is fundamental knowledge that all nurses are taught in nursing school. (Tr. 3027; see Ex. R-47, p.744 reference to checking the patient's wristband).[2]

The two-nurse bedside verification has been the basic standard of care across the nursing profession for decades. (Tr.1862-64, 3027-28; Ex. R-47).

[2] Similarly, it is fundamental to the nursing profession as a matter of education, training, licensure, ethics, as well as a legal mandate, that all entries in the medical record must be true and accurate. (Tr. 3063-64, Ex. R-45). Ex R-45 is a relevant section from the applicable New York State regulations. Ex. R-46 is a relevant section from the applicable federal regulations; the exhibit was not admitted since the Judge can take the information on judicial notice as set forth at 42 CFR 482.24. CMC policy also makes clear that "[f]alsification of data is not allowed." (Ex. R-44).

Despite this, errors still can – and occasionally do – occur, with catastrophic results (Tr. 1850-52), as demonstrated by a simple Google search for "wrong blood transfusion cases," the results of which we respectfully ask Your Honor to take judicial notice of.[3]

Thus, the requirement of a two-nurse bedside verification for blood transfusions has been listed as a National Standard of Care by the Joint Commission every year for the past several years, including in 2016 and again in 2017. (Tr. 3065; Ex. R-48).

The overwhelming evidence establishes that nurses at CMC have consistently been performing the required two-nurse bedside verification in all known cases for many years leading up the incident on September 11, 2016 ("9/11/16"). There is no record of any instance other than 9/11/16 involving a failure to perform the two-nurse bedside verification in the Medical Center's Incident Reporting System. (Ex. R-23). The Blood Transfusion Cards that are maintained in the medical record for all patients receiving transfusions and in CMC's Blood Bank records establish that **ALL** nurses have routinely and consistently certified to performing the two-nurse bedside verification before starting a blood transfusion. (See Tr.; 3050; Ex. R-62, R-64, R-65, R-66, R-68, R-69, R-70, R-73, GC-5, GC-6). Other than on 9/11/16, no patient or patient advocate has ever complained about a failure to conduct the two-nurse bedside verification. (Tr. 3050). The medical records establish that the patient who did complain about the incident on 9/11/16 (referred to throughout this brief as "Patient SF") received 22 blood transfusions involving up to 44 RNs at CMC, and the two-nurse bedside verification was performed in every instance except for the transfusion in issue. (Ex. R-7, R-8).

[3] See, e.g., news accounts of patient death from wrong blood in July 2014 at Lehigh Valley Hospital in Hazleton, PA, in July 2013 at Coney Island Hospital in NYC (NY Post headline "Blood on their hands"), in Sarasota, FL; and so on.

Four years earlier in October 2012, a "Near Miss" incident occurred at CMC in which the wrong blood was hung on a patient's intravenous ("IV") pole, but fortunately the error was discovered before potentially killing the patient. There is a great deal of evidence in the record about this October 2012 Near Miss incident which was a seminal event at CMC. (See Ex. R-35, R-37, GC-53, U-3). Although the two-nurse bedside verification requirement had been a longstanding fixture prior to this event, additional safeguards were added to CMC's Blood Product Administration Policy in the aftermath of this Near Miss event, including a new double tier two-nurse verification process, with the first two-nurse verification being performed before the blood enters the patient room typically at the nurses' desk. (See Ex. R-37, R-42, R-74, R-75). All nurses were trained on the new Policy in 2013 (Tr. 1870), and the evidence establishes that all nurses are continually trained on CMC's Blood Product Administration Policy on a periodic basis via the hospital's computer-based training system. (See Tr. 1872; Ex. R-49, R-50, R-51, R-64). It is undisputed that Ms. Marshall and Ms. Lamb completed training on the Blood Product Administration Policy as recently as July 2016, within two months of the 9/11/16 incident. (Ex. R-49, R-50, R-51).

CMC's Blood Product Administration Policy that was in effect throughout 2016 provides the following in relevant part:

> **Standard**
>
> …. The entire blood transfusion process should be considered a safety zone process. Individuals participating should be identified and not interrupted during all steps.
>
> ….
>
> **Transfusion of Packed Cells or Whole Blood**
>
> 12. A two-tier verification should be implemented on inpatient floors:

A. Before taking blood into the patient room, the two nurses must verify the blood against the order and chart for correct patient name, blood type, type of blood product. No product should enter the patient room until it is verified.

B. Inside the room, verification must occur matching the blood to the patient with two identifiers (name, date of birth [DOB]); verbally and against the patient wrist band.

C. The blood must not be hung before the verification has occurred. If the nurse is interrupted for something more pressing, the incoming nurse will need to re-verify that the product is correct before transfusing.

13. Perform the 2-RN bedside checklist:

A. Verify the provider's order.

B. Verify that the consent has been signed by the patient (or appropriate representative).

C. Check the blood bag number, expiration date, blood type and Rh.

D. Two RNs must identify the patient at the bedside by asking the patient his name or her name and date of birth. This is compared to the patient's armband and blood Transfusion Card.

E. Transfusion card will be completed in its entirety by two RNs/GNs and upon completion returned immediately to the lab.

(Ex. GC-3).

Accordingly, two separate verifications by two nurses must occur before the transfusion can begin. The first verification occurs before the blood can be brought into the room. During this verification, the two nurses must examine the patient information as well as the information on the blood bag from the laboratory. Both nurses must verify that everything matches, at which point the blood can be brought into the patient's room.

The second verification occurs once the blood is in the patient's room. Again, the two nurses must verify the patient's name and date of birth (which requires the nurses to check the patient's identification bracelet or obtain verbal confirmation from the patient if alert), and compare that information against the order and label on the bag. At that point, the blood bag can be hung and the infusion commenced.

This second verification has at all times been a part of CMC's Blood Product Administration Policy and is a National Safety Standard. (Ex. GC-3, R-48). Indeed, this final two-person bedside verification process is absolutely fundamental as a final safeguard against a potentially fatal error prior to starting a blood transfusion. In fact, it is the final bedside verification that saved the patient in October 2012 from receiving the wrong blood. (cite). It is the last line of defense before a patient receives blood and is imperative in ensuring patient safety.

Pursuant to a national program, CMC has prominently placed posters in all patient rooms encouraging them to advocate for themselves. The poster reads as follows:

To prevent healthcare errors, patients are urged to

Speak Up!

Here's how patients can get involved in their care:

1. SPEAK UP if you have questions.
2. PAY ATTENTION to the care you are receiving – make sure you're getting the right treatments and medications by the right health care professionals.
3. EDUCATE YOURSELF about your diagnosis, medical tests and treatment plan.
4. ASK a trusted family member or friend to be your advocate.
5. KNOW what medications you take and why.
6. PARTICIPATE in all decisions about your treatment.

Ask your nurse or physician
if you have any questions or concerns

(Ex. R-2) (large boldface type in original).

Due to her medical condition, Patient SF had to undergo numerous blood product transfusions leading up to the incident on 9/11/16. CMC records show that during the period from July 26 to October 3, 2016, she received a total of 31 blood transfusions while being treated in CMC's Oncology Center, Infusion, 4 South (medical/surgical unit), 4 North (med/surg unit) and the ICU. (Ex. R-7). During her 10-day hospitalization from September 5th to September 15th, she received a total of 13 blood or blood transfusions. (Ex. R-8). As a result, Patient SF became very knowledgeable about the blood product administration process, consistent with the advice given to all patients to pay attention to their care, educate themselves, know their medications and treatments, and participate in decisions about their care. Patient SF knew the drill. In every single case, except on 9/11/16, the nurses who administered her transfusions followed the exact same protocol prior to starting the infusion, included a two-nurse verification at the bedside in which they checked her ID wristband, date of birth, the doctor's order, the information from the lab, etc., and confirmed that everything was correct prior to hanging the unit of blood and starting the infusion.

In addition to advocating for herself, on 9/11/16, Patient SF also had a family member acting as an advocate; namely, her sister Star York, who happened to be a critical care nurse at Eastern Maine Medical Center in Bangor, Maine, and thus was very knowledgeable in the proper blood product administration protocol. (Ex. R-6).

After receiving a of total of 22 previous blood transfusions at CMC, including 11 previous transfusions during this particular hospitalization, including 4 in the ICU – all of which were handled by the nurses involved in accordance with the National Safety Standard and CMC Policy with respect to the two-nurse bedside verification process – on 9/11/16, Patient SF's primary nurse,

Anne Marshall, came into Patient SF's room with a unit of blood for transfusion by herself without any accompanying nurse. (Ex. R-4). Ms. Marshall then proceeded to hang the blood without performing any of the necessary checks to ensure against a potentially fatal error. Patient SF was fully alert and oriented, and she followed the hospital's advice by speaking up and asking her nurse a question in which she expressed her concern about the lack of standard safeguards. (Ex. R-4). Instead of responding to Patient SF's concern by getting the second nurse and performing the required two-nurse bedside verification, Ms. Marshall proceeded to administer the transfusion by herself in blatant violation of a critical patient safety standard and CMC Policy. (Ex. R-4). Ms. Marshall then left the room, leaving Patient SF feeling vulnerable and in fear that possibly the wrong blood type was being infused into her body, at which point her sister immediately went to the bedside and verified that it was in fact the correct blood. (Ex. R-4).

Shortly thereafter, Patient SF called the Charge Nurse at the time, RN Scott Goldsmith, into her room, and she asked him to please close the door. She then asked if it was common practice to check a patient's ID bracelet before starting blood, and Mr. Goldsmith said that it was. Patient SF proceeded to tell the Charge Nurse that Ms. Marshall had hung the currently infusing blood without checking her ID. (Ex. R-4). Mr. Goldsmith immediately checked the unit of blood and attached paperwork, and apologized to Patient SF. (Ex. R-4).

Shortly thereafter Ms. Goldsmith approached Ms. Marshall and asked her if she had checked the patient ID against the blood before starting the infusion. Ms. Marshall responded that Ms. Lamb and her relied on the patient's sticker sheet at the nurses station to verify the information, thus admitting both that no two-nurse bedside verification took place, and that Ms. Marshall never checked the patient's ID before hanging the blood. Ms. Goldsmith emphasized the importance of checking blood at the patient's bedside, to which Ms. Marshall responded that she understood and

would do so in the future. (Ex. R-4). Mr. Goldsmith also spoke with Ms. Lamb, the co-signer of the Blood Transfusion Card. Ms. Lamb verbalized that she understood the correct procedure for checking blood, and told the Charge Nurse that she would follow the correct procedure from then on. (Ex. R-7).

September 11, 2016 was a Sunday. Early on the following morning, Monday, September 12, Mr. Goldsmith spoke with Assistant Vice President of Patient Services, Linda Crumb, and told her what had happened. Mr. Goldsmith told Ms. Crumb that he would be filing an incident report in CMC's incident reporting system, which he did on September 13. In his incident report, which represents his contemporaneous documentation of the events, Mr. Goldsmith described his interaction with Patient SF and with the two responsible nurses as follows:

> [Patient SF] called me into her room and asked me to close the door. She then asked me if it was common practice to check a patient's ID bracelet before starting blood. I informed her it was. **She then informed me that the nurse, Anne Marshall had hung the currently infusing blood without checking her ID.**
>
> I noted that the attached paperwork had all the appropriate initials and vital signs. I approached Anne to ask if she had checked the patient ID against the blood before starting the infusion. **She [Marshall] informed me [Goldsmith] that she and another nurse [Lamb] had used [the] patient's sticker sheet at the nurses station to confirm the information.** We than [sic] had a brief discussion on the importance of checking blood at patient's bedside. Anne stated that she understood and would do so in the future.
>
> I spoke with Loran Lamb, the cosigner of the paperwork. She verbalized the correct procedure for checking blood and stated that she would do so from now on.

(Ex. R-4) (emphasis added).

Once entered, the incident reporting system generated automatic electronic notifications to several individuals, including Ms. Crumb who in addition to her regular duties was also serving in

the capacity of Acting Director of the ICU at the time (i.e. the unit where the incident occurred), Quality Improvement Specialist Anna Bartels, Quality & Patient Safety Specialist Polly Votaw, Chief Patient Safety Officer & Director of Quality and Patient Safety Karen Ames, and Risk Manager Brenda Twomey. Ms. Crumb also informed her immediate supervisor, Director of Patient Services and Chief Nursing Officer Deb Raupers. Because the matter involved a patient complaint, Ms. Raupers directed Ms. Ames as Director of Patient Safety to conduct an investigation into the 9/11/16 incident, with assistance from Ms. Crumb based on her clinical nursing expertise.

CMC senior management immediately recognized two realities: (1) this was a serious patient complaint about a violation of a National Safety Standard and clear CMC policy that could not be ignored; and (2) the primary nurse involved happened to be Anne Marshall who was a highly visible proponent of an ongoing effort by a labor union to organize the CMC nurses, and who was the subject of recent unfair labor practice charges against CMC. CMC proceeded with the investigation without regard to Ms. Marshall's union support, knowing full well that any adverse employment action that might result would be controversial and would likely be the subject of additional unfair labor practice charges.[4]

On September 16th, Ms. Ames and Ms. Raupers interviewed Patient SF by telephone since she had already been discharged. Ms. Ames' contemporaneous documentation of this conversation appears in her entry into CMC's incident reporting system as follows:

> Interviewed pt [i.e. patient] today. Patient described situation that led to her concern. She stated that in all other instances of hanging

[4] Given the seriousness of the patient complaint and the key facts that were known very early in the investigation (i.e. willful failure to perform critical patient safeguard in high-risk procedure and deliberate falsification), combined with the fact that one of the nurses was a very vocal union proponent and the subject of prior unfair labor practice charges, CMC's Vice President of Human Resources Brian Forrest and Vice President of Communications John Turner, began to prepare while the investigation was still underway for the worst possible outcome and the likely fallout in the event that CMC reached the conclusion that the responsible nurses should be discharged for their severe misconduct.

> blood two nurses always came to the bedside to conduct verification and pt ID. **She noticed that this time only one nurse hung the blood without carrying out these steps or checking the name band** and wondered why the difference. The patient questioned the nurse [Marshall] and was told by the nurse she [Marshall] (and the other nurse [Lamb]) checked everything at the nurse station. The pt stated her sister who is an RN witnessed this and was concerned and checked labels against blood bag. I thanked the patient for speaking up and assured her we take patient safety seriously – and that we would address the situation with the employee.

(Ex. R-4) (emphasis added).

Ms. Raupers also documented the telephone interview in a contemporaneous email that she drafted and later sent on September 20th. In her email, Ms. Raupers recounts the following:

> Friday 9/16/2016 Karen Ames and I called [Patient SF] to look into a patient complaint. We had rounded on the patient that am to find that she was discharged Thursday evening. I introduced myself and asked her if she would explain to me her complaint of what occurred when she was given blood in the ICU. **[SF] explained that her nurse came into the room and hung a unit of blood and started to infuse it and was going to walk out. [SF] asked the nurse "don't you need to check my name and band" and follow some sort of protocol and the nurse responded "I already did that at the desk" and then walked out of the room.** [SF's] sister, who is an RN, was sitting at the foot of her bed and was described as being "appalled". The sister immediately got up and checked the blood herself to make sure it was [SF's]. They then contacted the charge nurse to explain what had occurred. **[SF] stated she felt safe only after her sister who is an RN checked her blood.**
>
> Karen and I explained that we have policies and procedures that staff must follow and that we would address the issue. We thanked her for bringing this issue forward and [SF] stated that she "felt like she had to speak up". She had read the "speak up flyer" on her wall and felt that this was to[o] important to let go. **She was upset that after she questioned the nurse, the nurse just excused it away.** I reassured [SF] that we were taking this incident seriously and that we are proud that she partnered with us in her care and was an advocate for herself.

(Ex. R-5) (emphasis added).

Ms. Ames and Ms. Raupers also asked Patient SF if she could provide her own written statement describing the incident, which Patient SF did by email on September 19th. The patient's own contemporaneous written account states the following:

> I have [diagnosis]. In July I started needing to have blood transfusions. **From day one the nurses talked me through the protocol they would be following whenever they administers [sic] a blood product for me. Call for blood, wait. Get Tylenol and Benadryl. Blood arrives, 2 nurses are in the room with the blood. They scan my name band, they ask me my name and birthdate. They read my name and number off my wrist and compare it to the paperwork. They then read the numbers on the blood bag and compare it to the paperwork numbers. If everything matches, then they start the blood.**
>
> Unfortunately I ended up in the hospital on September 5th.… In the next few days numerous blood products were hung and the protocol was followed. On September 11th it was determined that I would need a bag of blood. Nurse calls, we wait. My sister and aunt were in the room. **The nurse (Anne) comes in hangs the bag and starts the blood. I looked at her and said "What about the protocol?" And she said "Oh we did that at the desk." – and left the room.** My sister who is an RN in the state of Maine, ran over to the blood to check the numbers. I said "This isn't how it's ever been done." The numbers checked, so I relaxed, but when Scott came into the room (I think he was charge nurse for the day) I voiced my major concerns to him. **All previous nurses had made me aware of the protocol and led me through it – this nurse did none.** Scott told me he would speak to the nurse, and let me know after he did.
>
> **I need the hospital to be aware of this breech [sic] of protocol and seriousness I felt being vulnerable in my bed.**

(Ex. R-6) (emphasis added).

On September 20th, Ms. Ames spoke individually with four other ICU who working at the time about blood administration practices on the unit, Terry Ellis, Joan Tregaskis, Anita Tourville and Ananda Szerman. All four stated that they understood the policy with respect to the two-nurse bedside verification. Three out of the four (Ellis, Tregaskis and Tourville) stated that they always

do perform the final two-nurse verification at the bedside, but they couldn't speak for what other nurses do. The fourth nurse, Ms. Szerman made a point of noting that two nurses verify the blood at the desk – which is consistent with the first two-nurse verification as required by CMC policy – but she was nonverbal and evasive with respect to the second required two-nurse verification at the bedside. However, when pressed by Ms. Ames over whether Ms. Szerman and other nurses document on the Blood Transfusion Cards differently from what they are actually doing, Ms. Szerman shrugged and said no, thus indicating that the attestations to a final two-nurse verification at the bedside are in fact accurate. None of the four nurses came forward with any actual instances that they were aware of in which the bedside verification had not been carried out. (See Ex. R-9).

Ms. Raupers and Ms. Ames then interviewed the patient's sister, Star York, who happened to be a critical care RN in Maine, and who witnessed the 9/11/16 incident. Ms. York reported that when SF asked "where is the 2nd nurse for the blood transfusion, [Ms. Marshall's] reply [was] 'We don't have to do that;' [and when] questioned why another nurse did, [Marshall's] reply [was] 'That must have been a new nurse.'" Ms. York also stated that, "As an experienced critical care RN, I was shocked by the responses." (Ex. R-78).[5]

Ms. Ames reviewed the Blood Transfusion Card for the patient's 9/11/16 transfusion. It had been completed by both Ms. Lamb and Ms. Marshall. In the box with the bold heading "Below information must be verified at Patient Bedside" both nurses provided their initials and signed the card certifying that the correct procedures had been followed, even though according to the patient's and family member's report, this was not the case. (Ex. GC-2).

[5] Ms. York was also interviewed via telephone on September 27th by CMC's Vice President of Public Communications, John Turner, during which Ms. York stated that, "[a]s an experienced critical care RN, [she] was shocked by the responses" that Ms. Marshall gave to Patient SF regarding the glaring lapse in safety standards. (Ex. GC-18).

On September 21st, Ms. Ames interviewed Ms. Lamb about the 9/11/16 incident, with Ms. Crumb also present. Ms. Lamb said she already knew what this was about and immediately admitted that she made a mistake and said she was sorry. Ms. Lamb went on to acknowledge that she understood the policy; that she recently completed the training and nothing was confusing about that; and that she knew that blood administration is a high-risk procedure and that an error could be fatal for the patient. When asked about any contributing factors, Ms. Lamb said that the unit was busy at the time, but she knew that this was no excuse for failing to perform the two-nurse verification at the bedside. (Ex. R-11). In a follow-up conversation Ms. Lamb confirmed that the initials on the Blood Transfusion Card were in fact her initials, thus admitting that she had falsified the medical record by certifying that the two-nurse verification was performed at the patient's bedside. (Ex. R-12, R-13).

Since Ms. Lamb had stated that the unit was busy at the time of 9/11/16 incident, Ms. Ames reviewed the staffing record for that shift. The staffing record showed that: (1) each ICU nurse had two patients, which is the normal ratio; (2) the Charge Nurse had no patient assignment and was readily available to assist as needed; and (3) there was an RN designated as on-call who could have been called in but was not. (Ex. GC-39).

In her capacity as Acting ICU Director, Ms. Crumb subsequently telephoned Ms. Lamb (who was not scheduled to work that day) to inform her that she was being placed on suspension with pay pending completion of CMC's investigation and a final determination. At Ms. Lamb's request, Ms. Crumb and Vice President of Human Resources Brian Forrest met with Ms. Lamb in-person on September 22nd, and confirmed her suspension pending a final decision. (Ex. R-12, R-13). Ms. Crumb followed up with a confirming letter to Ms. Lamb dated September 23rd. (Ex. GC-40).

Ms. Marshall was away on a pre-scheduled extended vacation following the incident report. Her immediate supervisor left multiple messages for Ms. Marshall to contact her about setting up a meeting, but Ms. Marshall did not respond to these messages. Although CMC did not technically place her on suspension and instead was waiting for her to return from vacation in order to obtain her description of the situation before proceeding any further, Mr. Forrest determined that under the circumstances it was prudent for CMC to also remove Ms. Marshall's computer access at the same time as Ms. Lamb's pending completion of CMC's investigation and a final determination as to both nurses.

In addition to the patient safety/disciplinary investigation and in accordance with normal practice, the matter was also submitted to CMC's Nursing Peer Review Committee for their review and input. This is a standing committee consisting of RNs from across different care areas at CMC. After reviewing the incident including the surrounding circumstances and all relevant information, each committee member renders one of four possible judgments: (1) Most experienced, competent practitioners would have managed the case in a similar manner; (2) Most experienced, competent practitioners might have managed the case differently; (3) Most experienced, competent practitioners would have managed the case differently; or (4) Reviewer uncertain, needs committee discussion. In this case an initial Nursing Peer Review Committee meeting was inconclusive because according to the medical record the proper two-nurse bedside verification had taken place, as certified by Ms. Marshall and Ms. Lamb on the Blood Transfusion Card. However, in a follow up meeting on September 23rd, after reviewing the patient complaint, the Nursing Peer Review Committee members unanimously concluded with respect to the conduct of both ICU nurses who were involved in the September 11th incident that, "3 – Most experienced, competent practitioners would have managed the case differently." (See Ex. R-15, R-16).

All units of blood and other blood products for patient infusion are prepared and handled by CMC's Laboratory Department, and those units are administered under the license of the Medical Director of Laboratories. (Tr. 1841-42). Dr. Daniel Sudilovsky is Chairman of Pathology and Laboratory Medicine and Medical Director of Laboratories for CMC. In an email to Ms. Raupers on September 26th, Dr. Sudilovsky thanked her for debriefing him on the September 11th incident involving a unit of blood from his lab, and proceeded to give his opinion on the matter as follows:

> [T]he lab and nursing leadership have worked diligently to establish standard operating procedures relating to the transfusion of blood products. We agree that **errors in the transfusion of blood products (on the lab or nursing side) are exceedingly dangerous and can lead to rapidly catastrophic/lethal outcomes**. The current standard lab and nursing procedures (most recently updated 7/16) are based on best practices and, when followed to the letter, are designed to optimally ensure patient safety. It is also clear to me that the CCU nursing leadership has well developed educational programs in place and that both nurses involved in this patient complaint have been thoroughly educated and have signed off on these procedures. I understand both individuals involved are experienced nurses as well.
>
> **After much consideration, I can only conclude from these facts that the nurses in this case acted in a wantonly and willfully reckless manner by sidestepping the fail safes of our standard operating procedures and endangered this patient's life in doing so**.[6] Not following protocol to positively identify the patient represents a clear near miss/or potential serious harm scenario. As experienced nurses, this represents a particularly egregious infraction and I have little reason to believe that this would not be repeated at some point in the future or that this form of disregard for protocols will not be passed on to less experienced staff, if they are in positions to do so.
>
> **As Laboratory Director for CHS, I feel in the strongest of terms**

[6] In his testimony, Dr. Sudilovsky likened this to passenger airline pilots skipping the mandatory pre-flight safety checklist. Such reckless behavior would not be excused by the fact that the plane did not crash, nor was the wanton disregard for patient safety exhibited by the nurses in the 9/11/16 incident excused by the fact that the the patient did not actually end up receiving the wrong blood. (Tr. 1851-52).

> **<u>that these two individuals should not be in positions in which their duties or functions as nurses could again jeopardize patient safety in our system</u>**.

(Ex. R-17) (emphasis added).

At no point did Ms. Ames or Ms. Raupers identify the two nurses involved in the 9/11/16 incident, nor did Dr. Sudilovsky have any independent knowledge of the nurses who were involved. (Tr. 1886-87). His evaluation of the incident was based solely on the facts of the case, and his opinion about the wanton and willful recklessness of the two ICU nurses responsible for the 9/11/16 blood transfusion for Patient SF could not have been based on any union support or other protected activity. When testifying about the seriousness of this incident, Dr. Sudilovsky expressed his reaction to the behavior of the responsible nurses as follows:

> I came to the conclusion that in my career, certainly not at CMC, [I] had never encountered a situation where a nurse or other medical professional at any level would willfully ignore standard operating protocols that were designed for patient safety, especially not with something where the potential consequences can be so catastrophic …. They knew how to do it right. They chose not to. That was number one. Secondly, by signing this sheet … [the transfusion card] … this is a legal attestation. This is a document of the medical record…. [W]hen I know they didn't do it right, I know the patient and the patient's family who are knowledgeable tells me they didn't do it right and they signed that they did, they're lying to me…. [T]his is outside my experience as a medical professional that people would do this, especially as experienced nurses they must know better.

(Tr. 1883-85).[7]

Ms. Ames, along with Ms. Crumb and Mr. Forrest, met with Ms. Marshall immediately

[7] On cross examination when asked a hypothetical question about whether a nurse who documents that there was no adverse reaction but later the patient does exhibit an adverse reaction, would that be considered falsification of the medical record, Dr. Sudilovsky responded as follows: "The nurse at that point may have misinterpreted information on the record. There may have been a mistake, I could not consider that to be a willful and intentional falsification. Mistakes happen. Willful signing of an attestation that you did something when you did not do it is a completely different matter." (Tr. 1906).

upon her return from vacation at 7:00 a.m. on October 4th to interview her concerning the September 11th incident.[8] When asked to describe the possible consequences of giving a patient the wrong blood, Ms. Marshall at first stated that she did not know, but subsequently acknowledged that it could be fatal. Ms. Ames then discussed the importance of following the protocols in place to safeguard against any such error, and Ms. Marshall responded that there must be something wrong with the policy because she contended that CMC nurses were generally not following it. Ms. Marshall went on to claim that she did not remember the need for a final two-RN check at bedside and that they were often too busy and short-staffed to take two RNs away from the nurses station to go into the patient room. Later in the interview, however, when asked again why she did not conduct the final bedside verification, Ms. Marshall admitted that she knew this was policy and stated that she would have done it correctly, but given how busy she was at the time she weighed the risks and benefits and determined that it was not necessary since other nurses purportedly don't do it. Thus, she admitted that she knew the policy but chose not to follow it. Ms. Marshall also acknowledged that it was her signature on the Blood Transfusion Card just under a bold header on the form stating that "The below information must be verified at the patient bedside," but claimed that she never noticed that statement on the form, even though nurses are healthcare professionals and are responsible for understanding and completing all medical records accurately.

Contrary to Ms. Marshall's contention that she was too busy to carry out the final check at the bedside, CMC's investigation revealed that no emergencies were occurring on the unit at the time of Patient SF's transfusion; staffing records revealed that each ICU nurse had two patients which is the normal ratio; the Charge Nurse had no patient assignment and was therefore readily

[8] Ex. R-20B is a complete stipulated transcript of an audio recording of this interview. (See also Ex. R-19).

available to assist as needed; and that there was an RN designated as on-call who was never called in. When Ms. Ames asked Ms. Marshall how she could concentrate during the critical verification check at the nurses station while watching monitors, Marshall glibly stated that she can multi-task and that nurses do it all the time, even though there was no evidence to support her contention that ICU nurses routinely dispense with the two-nurse bedside verification, and despite the fact that the need to conduct a two-nurse bedside verification is taught in Nursing 101; it is a National Safety Standard; and it is clearly required by CMC Policy.

Following her interview of Ms. Marshall, Ms. Ames conducted a follow up interview of the Charge Nurse at the time of the 9/11/16 incident, Scott Goldsmith, the contents of which she described in an email that same day as follows:

> I spoke with Scott today at noon to finalize my investigation of the blood transfusion incident. Per Scott there was good staffing that day and Scott was unassigned as the charge nurse. There were no emergencies that day (there was a patient that was being transferred out but that did not impact this in any way per Scott). I asked Scott if Anne had asked for help, and he stated she did not. I also asked if there was any variation in practice with hanging of blood and he stated that the two person RN check is standard practice and that this is well known among nurses. He also stated he can't speak to what they do unless it is in front of him. He stated he does not know any reason that any RN would do this at the nurses station, it does not save any time whether you do it at the bedside or at the nurses station. After Scott spoke with the patient he asked Anne and Loran about this incident, Scott stated both Anne and Loran acknowledged that they had not done the RN check at the bedside and indicated that it would not happen again.

(Ex. R-21).

As part of her investigation, Ms. Ames also examined the staffing for that day and the incident reporting system to confirm that no incident involving failure to conduct a final bedside verification prior to a blood transfusion had ever been entered into the incident reporting system either by a Charge Nurse, Nurse Supervisor or Nurse Manager, or by laboratory staff who are

required to examine all Blood Administration Cards to ensure that they were properly completed by the responsible nurses. All of the hospital's records at least since the widely discussed Near Miss incident in October 2012 confirmed that all blood transfusions by nurses across all CMC units are scrupulously conducted in accordance with the Blood Product Administration Policy, including the final two-RN bedside verification, notwithstanding Ms. Marshall's assertions to the contrary. In fact, in comparing the Near Miss incident from 2012 where a nurse mistakenly hung the wrong bag, that error would have been discovered prior to harming the patient as a result of the final bedside check before starting the transfusion, which is the same final safeguard that Ms. Marshall and Ms. Lamb chose to omit when administering the blood transfusion on Patient SF. (Ex. R-23).

Upon completion of the investigation and based on all of the information that was obtained, Ms. Raupers and CMC concluded that the two ICU nurses: (1) knowingly and deliberately violated policy and committed a fundamental breach of patient safety that placed the patient in danger of a potential lethal outcome; (2) caused the vulnerable patient fear and distress because she was fully aware of the proper safety precautions that were being ignored; and (3) falsified the medical record by certifying that the two-nurse bedside verification had been performed. (cite). In addition, Ms. Marshall disregarded the patient's own concern about following the proper protocol, and Ms. Lamb failed to even enter the patient's room despite certifying that she had; all of which represented gross misconduct warranting immediate discharge.[9]

[9] The General Counsel went to great lengths to establish that there were numerous medication errors, errors in documentation, and various incidents where nurses made mistakes at CMC, that did not result in discipline or discharge. However, these other instances are not comparable to the 9/11/16 incident and are clearly distinguishable because none of the other incidents cited by the General Counsel or the Union involved deliberate purposeful action in knowing violation of CMC policy and of a National Safety Standard. Moreover, in the few cases where falsification of the medical record was found to be deliberate (as opposed to an oversight or involving a mathematical miscalculation), those nurses and other CMC staff members were all discharged immediately following CMC's discovery of the deliberate falsification. Thus, the General Counsel relies on apples-to-oranges comparisons when

CMC prepared written notifications to Ms. Lamb and Ms. Marshall informing them that they were being discharged as a result of the 9/11/16 incident and explaining the reasons for this action. However, in a meeting with Ms. Lamb on October 5th she availed herself of the opportunity that had been extended to her to resign in lieu of termination. (Ex. R-24, R-26, Ex. GC-41). Likewise in a meeting with Ms. Marshall on October 6th, she submitted a letter of resignation in which she falsely claimed that the blood transfusion policy "is continuously broken and leadership has been aware of it," and that "this has less to do with a policy and all to do with eliminating two Union organizers". (See Ex. R-27, R-29, GC-36, GC-37). CMC emphatically denies that its decision to discharge these two nurses was motivated in whole or in part by any union or other protected concerted activity. Instead, Ms. Lamb and Ms. Marshall were terminated due to gross misconduct that jeopardized patient safety and was discovered as a result of a complaint that was initiated by the patient and not by anyone in management.

Because Ms. Marshall and Ms. Lamb's misconduct involved a knowing falsification of medical records and deliberate violation of established safety standards, CMC determined that this constituted "professional misconduct" as defined by the New York State Education Department's ("NYSED") Office of the Professions, thus triggering an obligation to report. On October 20, 2016, Ms. Raupers filed an incident report with the NYSED Office of the Professions regarding both nurses. (Ex. R-61). Such complaints of professional misconduct are independently investigated by the respective Regional Office of Professional Discipline. In cases where the Regional Office finds "sufficient evidence" that misconduct has occurred, the case is referred to the Prosecutions Division of the Office of Professional Discipline.

On February, 17, 2017, CMC received notice that the Regional Office had completed its

pointing to various incidents involving mistakes; whereas the true apples-to-apples comparisons involving willful violations consistently resulted in immediate discharge.

investigation of Ms. Marshall's and Ms. Lamb's conduct. The Regional Office, finding sufficient evidence of professional misconduct, referred both cases to the Prosecutions Division for further action. Accordingly, Ms. Marshall and Ms. Lamb's licenses to practice nursing may be at risk due to the ongoing NYSED prosecution.[10]

ARGUMENT

POINT ONE:

THE OVERWHELMING EVIDENCE ESTABLISHES THAT THE TWO NURSES RESPONSIBLE FOR THE 9/11/16 INCIDENT WERE GUILTY OF GROSS MISCONDUCT.

The following facts are not in dispute:

(1) Blood Product Administration is a high-risk medical procedure that can result in an irreversible fatal reaction if a patient receives the wrong blood or blood product.

(2) The healthcare work environment is often very busy, stressful and full of distractions; and as such, it is an environment prone to errors if prudent safety precautions are not followed. This is particularly true in the ICU where nurses are caring for the Medical Center's most acute patients.

[10] Although the two letters from the State agency that governs licenses to practice nursing in New York State (one letter regarding Ms. Marshall, marked as Ex. R-72, and the other regarding Ms. Lamb, marked as Ex. R-79) were not admitted, the testimony about the contents of these letters is in the record, and detailed information about the agency's process is readily available on their website.

(3) Sentinel events where a patient dies from a medical error are tragic and costly, and can even result in the closure of a facility.

(4) Patient deaths from blood transfusion errors were fairly common many years ago, but numerous safeguards have been developed over the years to reduce the risk of catastrophic errors.

(5) The final most crucial safeguard to protect a patient who is receiving a blood transfusion from a potentially fatal outcome is the two-nurse verification performed at the bedside to ensure that the right patient is receiving the right blood.

(6) Nurses are taught in nursing school about the dangers of blood product administration and the importance of the two-nurse bedside verification process to prevent errors.

(7) Lippincot, a widely recognized text book on nursing and the primary reference tool used at CMC, provides that the standard of care for blood product administration is to perform a final two-nurse verification at the patient's bedside.

(8) The Joint Commission is a national accreditation body that publishes National Safety Standards which hospitals across America are legally bound to follow.

(9) The final two-nurse bedside verification for Blood Product Administration has been listed as a National Safety Standard for many years running, including in 2016 and in 2017.

(10) CMC has a detailed policy for Blood Product Administration that everyone involved in this high-risk medical procedure is required to follow.

(11) CMC's policy has evolved over time, including significant revisions following a seminal Near Miss event in October 2012 when the wrong blood was hung for the wrong patient resulting in the discharge of the responsible nurse.

(12) CMC nurses are regularly trained on the Blood Product Administration via the hospital's online training system, including in July 2016, just two months prior to the 9/11/16 incident.

(13) CMC policy requires that the blood product administration process be treated as a Safety Zone Process, meaning that participants must give the process their undivided attention, and that if interrupted must start over until they can complete the process from beginning to end without interruption.

(14) CMC policy requires that nurses perform a double-tier verification, first before the blood enters the patient's room (typically at the nurses station), and second at the patient's bedside just prior to hanging the blood and starting the transfusion.

(15) Staff nurses do not create National Safety Standards and do not create CMC policies; rather staff nurses are required to follow those standards and adhere to those policies.

(16) Staff nurses do not have discretion to ignore or violate National Safety Standards or CMC policies, and this is particularly true with respect to a high-risk medical procedure and a declared Safety Zone Process.

(17) Mistakes can and often do happen in the difficult healthcare working environment, which is why numerous systems are in place such as the entire Incident Reporting System and Quality Improvement function to analyze these mistakes, find root causes, and implement corrective measures to minimize the risk of such errors being repeated.

(18) CMC follows a Just Culture which means that not all incidents result in discipline for the employees involved, since other factors may have played a role, such as issues with equipment, policy and process ambiguities, environmental factors, etc. (Ex. R-58).

(19) The vast majority of incidents that occur result from errors due to mental lapses or momentary distractions or mistakes such as mathematical errors when calculating the right dose for a medication, or inadvertently omitting a step in a procedure or missing a box on a medical form. The vast majority of these

types of incidents do not result in discharge and may not result in any discipline or other corrective action beyond reeducation and counseling. This includes violations of the so-called "Red Rules" requiring two patient identifiers when administering medication and when collecting specimens.

(20) Willful deliberate violations of a National Safety Standard without good cause cannot be tolerated in an acute care setting where patient lives hang in the balance, particularly with respect to a high-risk medical procedure with a potential lethal outcome in the event of an error, particularly with respect to a declared safety zone process, and particularly in the ICU where patients are typically the most vulnerable.

(21) The importance of accuracy in documenting a medical record is fundamental to the nursing profession; accuracy of medical records is a legal mandate; and accuracy of medical records is essential to patient safety and quality care since the information in the medical record is relied upon in determining the course of the patient's treatment going forward.

(22) Mistakes in documentation can and do often occur; in the vast majority of cases these mistakes are due to errors of omission resulting from distractions or momentary mental lapses, again keeping in mind the difficult working conditions present in most

healthcare facilities; therefore, the vast majority of errors in documentation do not result in disciplinary action.

(23) When a nurse makes an entry in a medical record she/he is certifying that the information being entered is truthful and accurate; as a matter of professional responsibility nurses are duty bound to be familiar with the medical forms in the patient record and to insure that all entries are consistent with the instructions and the information being elicited on the form.

(24) Deliberate falsification of a medical record cannot be tolerated and is grounds for immediate discharge.

(25) Other than the 9/11/16 incident, although thousands of incidents are reported in CMC's Incident Reporting System every year, the evidence shows that no incident has ever been reported at CMC where nurses involved in blood product administration failed to perform the necessary two-nurse bedside verification.[11]

(26) Other than the 9/11/16 incident, the evidence establishes that CMC has never received a patient complaint, or complaint from a family member or other patient advocate, or from a staff member or anyone else, that blood was hung and a blood transfusion was started by a single nurse acting alone without

[11] This is true despite the fact that all staff members are regularly encouraged and are duty bound by the ethics of their profession and by a fundamental sense of morality to report situations in which they believe patient safety has been compromised which is the reason why the Incident Reporting System is actively and frequently used by CMC staff to make such reports.

having gone through a final two-nurse verification process at the patient bedside.

(27) An examination of hundreds of Blood Administration Cards completed by nurses in 2016 revealed that in every single case the two nurses involved certified in the medical record that they followed the two-nurse verification process at the patient's bedside as stated on the form; and frankly it defies logic and reason to presume that nursing professionals are guilty of widespread falsification of these medical records.

(28) Patient SF had a medical condition requiring numerous blood transfusions, and in all cases other than on 9/11/16, the nurses who administered those transfusions, of which there were 22 involving up to 44 nurses, all followed the same protocol by performing the required two-nurse bedside verification.

(29) On 9/11/16 Ms. Marshall and Ms. Lamb knowingly and deliberately violated CMC policy and a National Safety Standard by failing to perform the required two-nurse bedside verification when administering blood to Patient SF.

(30) Ms. Lamb admitted that she never even entered the patient's room; and that she understood the policy; and that she knew it was wrong; and that she was sorry.

(31) When interviewed during the employer's investigation into Patient's SF's complaint about the 9/11/16 incident, and at all

times prior to testifying at the hearing in this case, Ms. Lamb never once claimed that it was common practice among nurses in the ICU to ignore the two-nurse bedside verification.

(32) Ms. Marshall admitted that she entered Patient SF's room with the unit of blood unaccompanied by a second nurse and that she never performed the required two-nurse bedside verification process in violation of CMC policy and in violation of a National Safety Standard.

(33) Ms. Marshall further admitted that Patient SF spoke up and questioned why normal safety protocols were not being followed; yet Ms. Marshall deliberately chose to proceed to administer the blood without following those protocols by bringing in a second nurse and performing the two-nurse bedside verification.

(34) When questioned about the 9/11/16 incident during the employer's investigation, Ms. Marshall brazenly declared that does not believe that a two-nurse bedside verification is necessary, and that she can determine on her own whether or not to follow the policy because she is fully capable of multitasking.

(35) During the employer's investigation into the 9/11/16 incident despite asking several staff nurses, none of them ever came forward with even a single report of an actual specific instance

in which other nurses had failed to perform the required two-nurse bedside verifications.

(36) On the Blood Administration Card that became part of Patient SF's medical record when completed by the nurses who administered her blood transfusion on 9/11/16, in the section of the form immediately beneath a bold heading stating that "The following information must be verified at the bedside," both Ms. Marshall and Ms. Lamb placed each of their initials in four different boxes and placed their full signatures immediately below the four boxes, thus certifying that they had in fact verified the necessary information at the patient's bedside; and by doing so they admittedly falsified Patient SF's medical record.

(37) CMC has a consistent past history of immediately discharging any nurse or other staff member who it discovers has deliberately falsified a medical record.

(38) The General Counsel failed to produce a single example of an instance in which a CMC employee who was found to have falsified a medical record was not promptly discharged for such misconduct.

(39) Likewise, the General Counsel failed to produce a single example of an instance in which a CMC employee who was found to have deliberately violated a National Safety Standard

and CMC policy with respect to a high-risk medical procedure was not promptly discharged for such misconduct.

The above facts are supported by the overwhelming evidence in the record gleaned from thousands of pages of contemporaneous Medical Center documents and from the testimony of dozens of esteemed healthcare professionals, and are essentially not in dispute. These facts clearly establish beyond any shadow of a doubt that Ms. Marshall and Ms. Lamb both committed two acts of gross misconduct on 9/11/16 when they knowingly and deliberately violated the two-nurse bedside verification requirement, and when they falsely certified to having performed the two-nurse bedside verification process in the medical record for Patient SF. These acts of gross misconduct had nothing whatsoever to do with any protected activity, and the patient generated complaint had nothing whatsoever to do with any protected activity.[12]

[12] During the course of their testimony, Ms. Marshall and Ms. Lamb both made a long list of significant admissions. Ms. Marshall admitted: (1) that blood product administration is a high-risk procedure with a potentially lethal outcome (Tr. 1258, 1261); (2) that she had just reviewed the blood administration policy in July 2016 (Tr. 1260, 1274, 1322-1323); (3) that the policy provides for a two-tier verification process (Tr. 1262-1264); that it's is not okay for a nurse to skip policy with respect to a high-risk procedure (Tr. 1302, 1270-1271); that it's not okay for a nurse to skip policy in connection with a safety zone process with a potentially lethal outcome (Tr. 1303); that she knew that she did not take Loran Lamb with her into the patient's room and instead would be doing the bedside verification by herself (Tr. 1303); and that she did not follow the policy (Tr. 1312). Ms. Lamb admitted: (1) that blood-product administration is high-risk procedure and a patient can die if they receive the wrong blood (Tr. 1581, 1583); (2) that she was aware of the blood administration policy and had just completed trained on it in July 2016 (Tr. 1546, 1575-1576, 1578); (3) that the two-nurse bedside verification is a National Safety Standard (Tr. 1581-1582, 1591); (4) that a nurse's responsibility is to follow policy (Tr. 1575); (5) that she did not go into Patient SF's room with Ms. Marshall to verify the blood (Tr. 1546); (6) that when the Charge Nurse spoke to her following the patient complaint, she admitted she knew to him that she knew she was supposed to witness the blood in the room and apologized for not having done so (Tr. 1548); (7) that with respect to the Blood Administration Card, in the box where it says "Patient name,date of birth on bracelet, agrees with those on tag", you can't certify to that unless you're in the patient's room and looking at the bracelet on her wrist (Tr. 1603); (8) that she falsified the medical record and this is a serious breach of professional responsibility (Tr. 1605); (9) that she was immediately worried about her nursing license (Tr. 1612-14); (10) there was no shortage in staffing and there was a charge nurse on so there were no emergencies or any other extreme circumstances (Tr. 1616-17); (11) she made the decision to never enter the room and there was no real reason why she chose not to. (Tr. 1625-26); (12) she knew this was a mistake and that this was a big problem and knew the patient was upset and had complained (Tr. 1628-29); (13) that she did do something wrong (1682–1683); (14) that she knew her decision to ignore the bedside verification procedure was unreasonable (1675–1676); (15) that there is no excuse for not completing the two-person check at bedside and in there was no issues with staffing (Tr. 1641-42); (16) that she understood the severity of this kind of situation (Tr. 1633-34); and (17) that she was dishonest in her affidavit

POINT TWO:

CMC'S DECISION TO DISCHARGE THE TWO NURSES IS FULLY SUPPORTED BY CONSISTENT PAST PRACTICE INVOLVING SIMILAR MISCONDUCT.

The two nurses responsible for the 9/11/16 blood transfusion were each guilty of committing two separate acts of gross misconduct: first, intentionally violating CMC policy and a National Safety Standard with respect to the most critical patient safeguard during a high-risk medical procedure by making a choice in Ms. Lamb's case to not even enter the patient's room, and by making a choice in Ms. Marshall's case to proceed without following protocol despite the patient's expressed concern over the lack of normal safety precautions; and second falsely certifying in the medical record that the required two-nurse verification process took place at the patient's bedside.

Although no previous case at CMC is exactly like the misconduct committed by the two nurses responsible for the 9/11/16 incident, the evidence shows that employees who engaged in similar acts of misconduct were promptly discharged by CMC upon discovering such misconduct:

- On May 12, 2009, RN M. Whitford was immediately discharged for falsification of records by entering test results without actually having conducted the tests. (Ex. R-30).
- On September 24, 2009, RN D. Noonan was immediately discharged for falsification of records related to crash cart documentation. (Ex. R-31).
- On December 10, 2015, Hospital Aide J. McDonald was immediately discharged for failing to weigh a patient and falsifying

before the NLRB wherein she stated that she had never heard about there being a patient complaint prior to being suspended but this was not true (Tr. 1649-50).

the patient record by entering fictional weight(s). Although Ms. McDonald had a history of prior disciplinary problems, these were unrelated and less serious than the failure to weigh/falsification which prompted her immediate discharge. (Ex. R-32).

- On February 16, 2016, Hospital Aide R. Smith-Parris was immediately discharged when it was discovered that she had entered false blood pressure readings on multiple patient records. (Ex. R-33).

- On June 23, 2016, RN V. Comstock was immediately discharged for failing to conduct various checks before administering a medication, including failing to scan the patient bracelet. (R-34).

Despite serving CMC with extensive subpoenas for records, the General Counsel and Union failed to uncover any evidence of a case in which immediate discharge did not result for a nurse or other employee who engaged in, either intentional violation of a National Safety Standard, or deliberate falsification of a medical record, much less both. Thus, there is no basis for inferring that the two nurses responsible for the 9/11/16 incident would not have been fired in the absence of protected activity. On the contrary, all of the record evidence supports the conclusion that in an acute care setting where patient lives are at stake and facilities are held strictly accountable by government regulators, there can be zero tolerance for staff members who intentionally violate National Safety Standards and/or deliberately falsify medical records. It is axiomatic that Section 7 does not immunize an employee from discipline or discharge for proven misconduct in accordance with the employer's policy and past practice.

POINT THREE:

THE OTHER INCIDENTS RELIED UPON BY THE GENERAL COUNSEL ARE CLEARLY DISTINGUISHABLE BECAUSE THEY DID NOT INVOLVE WILLFUL VIOLATIONS OR DELIBERATE FALSIFICATION.

It is undisputed that nurses are human; and that humans sometimes make errors; and that this is particularly true in the work environment of an acute care facility which is typically very dynamic and stressful. The evidence establishes that thousands of incidents are reported through CMC's Incident Reporting System every year.

The General Counsel went to great lengths to establish that there were numerous medication errors, errors in documentation, and various incidents where nurses made mistakes at CMC, that did not result in discipline or discharge. What the General Counsel failed to show, however, is that any of these other instances involved deliberate purposeful action in knowing violation of CMC policy and of a National Safety Standard, as opposed to unintentional mistakes that can occur for any number of reasons. We know that Ms. Marshall's decision to disregard the two-nurse bedside verification was a matter of deliberate choice on her part because she admitted to making this choice despite Patient's SF's expressed concerns over why this transfusion was not being done according to the normal safety protocol. None of the other cases relied upon by the General Counsel involve this type of deliberate decision to commit a serious patient safety violation.

The fact that other incidents may have involved giving a wrong dose of medication by accident, or even skipping a step in procedure, does not mean that the violation was willful since mistakes like this can and do happen due to other factors, such as an equipment issue with a scanner, or emergent conditions such as can sometimes occur in the Emergency Department, or

because of stress, distraction or plain forgetfulness; yet nothing like this accounts for the behavior of the two responsible nurses in the 9/11/16 incident. To the extent that any of the documents relied upon by the General Counsel in connection with other incidents do not clearly show all of the surrounding circumstances and various factors that may have contributed to the problem, then the General Counsel's burden of proof has not been met to show that these nurses were treated more harshly than other similarly-situated employees.

Furthermore, as just noted, the General Counsel cannot overcome the fact that in every case where CMC has discovered falsification of a medical record, the employee has been discharged immediately after such discovery. Once again in this case, Ms. Lamb and Ms. Marshall both admitted to placing their initials and their signatures in the spaces provided on the Blood Transfusion Card under the heading stating that the following checks must be performed by both nurses at the bedside, thus falsely certifying that the two-nurse bedside verification took place when in fact it did not.

POINT FOUR:

THE CLEAR WEIGHT OF THE CREDIBLE EVIDENCE ESTABLISHES THAT CMC NURSES HAVE CONSISTENTLY BEEN PERFORMING THE REQUIRED TWO-NURSE BEDSIDE VERIFICATION.

CMC issued a revised policy in early 2013 requiring double verifications by two nurses both outside the patient room before a unit of blood enters the room, and again inside the room at the patient's bedside before the bag holding the unit of blood can be hung and before the infusion can be started. From early 2013 up to the present, CMC management has not received any reports that any nurses have skipped steps or otherwise disregarded the policy and protocol when

administering a blood transfusion, nor would CMC ever condone any such lapse in duty since CMC treats patient safety as paramount and since an error in the blood transfusion process could prove deadly for the patient. This is especially true with respect to the final step in the process which is the bedside verification immediately prior to starting the transfusion, since any earlier errors would be discovered and caught in time to avoid inflicting actual harm to the patient.

Ms. Marshall and Ms. Lamb were made aware of the patient complaint on September 11, 2016, by Charge Nurse Scott Goldsmith. When Mr. Goldsmith spoke to them about the failure to perform the required two-nurse bedside verification, neither of them claimed that they were unable to do so due to extenuating circumstances, nor did either claim that skipping the most crucial final safeguard in a high-risk medical procedure by dispensing with the two-nurse bedside verification was common practice among nurses in the ICU. We know this because Mr. Goldsmith's contemporaneous documentation of his conversations with Ms. Marshall and Ms. Lamb on 9/11/16 set forth in the incident report (Ex. R-4) says nothing about any such excuses.

Immediately after her shift on 9/11/16, Ms. Marshall began an extended vacation, but she was in contact with some of her co-workers about the incident long before she was interviewed about the incident upon her return to work on October 4th. We know this because at the outset of her interview Ms. Marshall asserted that noncompliance with the Blood Administration Policy was common practice, and that she knew some of her coworkers had said so to Ms. Ames.

In fact, that is not what they told Ms. Ames. Each nurse who Ms. Ames talked to was careful to state that whenever they administered blood, they performed the two-nurse beside verification, but that they couldn't speak for others, thus implying that others may not have followed the policy, presumably in an effort to help Ms. Marshall. In other words, they may have wanted to help Ms. Marshall, but they stopped short of incriminating themselves by stating that

their personal practice was to conduct the final two-nurse verification at the bedside.

The closest that any of these other nurses came to claiming that they themselves had skipped the two-nurse bedside verification was Ms. Szerman who gestured toward the nurses desk, possibly implying that the final verification is sometimes done there, or possibly in reference to the initial verification which normally takes place at the desk. However, we know that even Ms. Szerman stopped short of actually stating that she had ever omitted the two-nurse bedside verification. Furthermore, when pressed by Ms. Ames and specifically asked whether her certifications on the Blood Administration Cards were inaccurate, Ms. Szerman answered no, meaning that her documentation was accurate, and thus acknowledging that her personal practice was to perform the final two-nurse verification at the bedside as attested to on the Blood Cards.

In addition to the lack of any mention of a purported common practice among ICU nurses to skip the final two-nurse bedside verification in the conversations that Ms. Marshall and Ms. Lamb had with Mr. Goldsmith on 9/11/16, Ms. Lamb never made this claim when she was interviewed about this incident during the employer's investigation, nor did she attempt to raise this as an excuse at the time of her subsequent suspension or her subsequent discharge. Instead, Ms. Lamb admitted that she knew it was wrong to have omitted the two-nurse bedside verification, and that she was sorry.

Following the discharges of Ms. Marshall and Ms. Lamb and the filing of unfair labor practice charges, the false narrative that skipping the two-nurse bedside verification was common practice seemed to take on a life of its own. The General Counsel attempted to prove this through several employee witnesses, but if anything their testimony was more notable for the admissions they made, than for supporting the false proposition of widespread reckless disregard for patient safety and rampant medical record falsification.

The General Counsel's first witness, ICU nurse Mary Day, testified that blood must be checked with another nurse (Tr. 68-69), and that it must be checked both at the desk and in the room with the patient. (Tr. 70). Ms. Day may have stated that she filled out the blood transfusion card out at the desk, but the important part is that she never actually performed the check outside the patient's room. (Tr. 86-87). Ms. Day was confused during her testimony and thought counsel for the General Counsel was referring to where nurses did the paperwork rather than where the check was actually performed. (Tr. 89-90). This is significant, because we know in the 9/11/16 incident the second nurse never even entered the patient's room. All of Ms. Day's testimony relates to where she filled out the card rather than where the actual check was performed. Significantly, Ms. Day testified that "normally the other nurse [the second nurse performing the check] would either go in and take a look herself and then leave." (Tr. 97). This testimony explicitly shows that both the primary and secondary nurse normally check the blood inside the patient room at the bedside. It is not as significant where the paperwork is exactly filled out, it is where the check itself occurs. The check itself is required to be performed outside at the desk and then by both nurses inside the room. This, as testified to by Ms. Day, is the "normal practice." (Tr. 97). Ms. Day testified that if she was the second nurse, not the primary nurse, "my practice would always be to walk into the room and verify for myself who it is." (Tr. 99, Tr. 105-106). She always entered the room and she did this "because we take safety very seriously." (Tr. 106-08, 114-15, 182-83, 305-07).

The General Counsel's next witness was ICU RN Christine Monacelli who testified that there were two checks, one at the desk "and then the two RN's go into the room and verifying the blood against the Patients name band and asking them." (Tr. 342-43). Ms. Monacelli was very confused by all of the questioning about the blood checks, and she appeared to answer whichever

way the question was asked. At one point she testified that "actually when I check blood and follow that I always thought to be the exact policy and procedure as per Cayuga Medical Center took everything in the room" (Tr. 576), but then she immediately turned around and stated that she actually performed some checks out at the nurses station (Tr. 577). When pressed, Ms. Monacelli testified that as the secondary nurse she usually did go into the patient's room but that she felt she was free to violate any care policy if she wanted to. (Tr. 597, 600). Ms. Monacelli was evasive, consistently confused and commonly changed her recollection and answers, and there was no credible evidence that anyone but herself violated this policy. (Tr. 663-66). Furthermore, she conceded that no managers or supervisor knew about any blood transfusions done without a two-nurse bedside verification process prior to the 9/11/16 incident. (Tr. 684).[13]

Joan Lynn Tregaskis is an RN in the ICU who testified as part of the General Counsel's case that she checked blood in the room, except in extremely rare circumstances. She testified that she could only recall about three times over the last 5 to 7 years when conditions on a two-nurse bedside verification did not take place (Tr. 913, 925, 947-48, 977-78), but she acknowledged that none of these incidents were ever reported to management. (Tr. 943). Ms. Tregaskis also

[13] Ms. Monacelli testified to an instance in which Charge Nurse Scott Goldsmith allegedly told her that she had failed to follow all steps in the blood transfusion process; however, the purpose of this testimony was unclear since she ended up stating that both nurses did in fact go into the patient's room for the final verification, and that this so-called "incident" was never reported to management. (Tr. 708-09). Even more mysterious was the testimony provided by the General Counsel's Hospital Aide witness Jennifer Delmage. She began by saying that she saw two nurses check blood at the nurses station and not in the patient room (Tr. 313); however, she then stated that both of the nurses went into the patient's room. (Tr. 314, Tr. 331-32). Thus she confirmed that the practice is to follow the policy which requires a desk check by two nurses AND a bedside check by two nurses. (Tr. 314). Ms. Delmage seemed to have little or no understanding about the blood product administration process and her entire testimony proved pointless.

acknowledge that the final two-nurse bedside verification is the most critical step in the blood product administration process. (Tr. 921).

Similar to Ms. Tregaskis, former ICU nurse Ananda Szerman testified the two-nurse verification generally happened inside the patient room, but not always. (Tr. 1082-83, 1111, Tr. 1148-49). She could not provide any specifics as to the occasions when the two-nurse bedside verification did not occur, except to say that such events were never reported. (Tr. 1132). Former Emergency Room nurse Louise McGarry only testified only about what Amanda Szerman allegedly told her, rather than from any direct knowledge. (Tr. 1160-63). Ms. McGarry acknowledged that she was aware of the policy and the requirement that two-nurse bedside verification requirement, and she did not testify that she ever failed to abide by this policy. (Tr. 1165-66).

ICU Nurse Anita Tourville Knapp testified that in very busy or chaotic situations she remembered occasions where two nurses did not do the bedside check but these incidents were never reported. (Tr. 1705-06, 1724, 1732-33). Her regular practice when acting as the secondary nurse was to join the primary nurse in the patient's room for the final verification. (Tr. 1707-08). She testified on cross examination that the omission of a two-nurse bedside verification was rare and she could not recall any specifics. (Tr. 1728).

Jacqueline Thompson testified that two-nurse bedside checks are generally performed, but she recalled one incident in the ICU when she thought Mr. Goldsmith was going to skip going in the patient room, but ultimately Mr. Goldsmith did go in the patient room to perform the two-nurse verification checks. (Tr. 1765-66, 1797). This was the only check she had done in the ICU and the two-side bedside verification check was performed, and she also testified that in every other

unit she was assigned to they also complied with the two-nurse bedside verification process. (Tr. 1766-67).

When all of this testimony is viewed as a whole, it refutes rather than supports the contention that omitting the two-nurse bedside verification was common practice. A couple of these witnesses claimed that they knew of only a few occasions over a multi-year period when a failure to conduct the two-nurse bedside verification had occurred, but they could not provide any concrete details about any of these occasions, and they all conceded that to the extent any such occasions existed, they were few in number, very rare, and never reported to anyone in management or to CMC's incident reporting system.[14]

Not only was the General Counsel's attempt to establish that two-nurse bedside verifications are routinely omitted at best very weak, but the evidence supporting the contrary conclusion that nurses at CMC have consistently and scrupulously adhered to the final two-nurse bedside verification requirement (except for the incident on 9/11/16) is overwhelming.

The October 2012 Near Miss incident is the only other known incident involving a serious and potentially lethal violation of the blood transfusion protocol. That instance did not involve a failure to conduct the two-nurse bedside verification, but rather involved breaches in protocol prior to that point for which the responsible primary nurse was promptly discharged. (Ex. R-35, R-

[14] A couple of the General Counsel's witnesses pointed a finger at former ICU Director Shawn Newvine, claiming that he was involved in one or more occasions when the two-nurse bedside verification was omitted. However, Mr. Newvine (who left CMC two years ago) testified pursuant to subpoena and forcefully rebutted these accusations. Mr. Newvine testified in a forthright and highly credible manner that throughout his long career as a Registered Nurse and as a manager he has fully understood the dangerous nature of blood transfusions, and the longstanding and strictly enforced two-nurse bedside verification requirement to ensure that no error ends up killing a patient; and that he has always performed the two-nurse bedside verification, and to his knowledge every nurse under his direction in the ICU at CMC had always performed the two-nurse bedside verification. (Tr. 2465-66, 2469-72). Mr. Newvine testified that performing a two-nurse bedside verification prior to a blood transfusion is "a well-known patient safety rule. It's published every year by the Joint Commission and the IHI. It's a national patient safety rule. It's just one of those golden rules you don't break." (Tr. 2472).

36).[15] From that time forward, strict adherence to the additional safeguards has been a continuing requirement for all nurses. CMH has no knowledge of any instance in which the required safeguards were not followed, other than the 9/11/16 incident. Furthermore, CMH searched its medical records relating to the more than 500 blood transfusions that have took place from January to September 2016, and in every case the two nurses certified in the medical record at the time of the infusion that they performed the final two-nurse verification at the bedside to ensure that no error would actually reach the patient. The one and only time that CMC is aware of when the proper safeguards in place since early 2013 through the present have not been followed was the 9/11/16 incident that was reported by Patient SF and that resulted in suspension/discharge of the two responsible nurses.

The following facts pertaining to the blood transfusions at CMC are not in dispute:

(1) CMC has not received any complaints or reports from a patient or from a patient's family member about an improper blood transfusion other than the complaint from Patient SF about her infusion on September 11, 2016, and the corroborating report from her sister who was present at the time and who happens to be a critical care nurse in Maine.[16]

[15] The assisting nurse did nothing wrong because he was not called to assist until after the primary nurse had already hung the wrong blood.

[16] It is undisputed and important to note that CMC performs many hundreds or thousands of blood transfusions every year, and that certain types of patients, particularly oncology patients, during the course of their treatment will receive dozens and dozens of transfusions. Like the patient in this case, most of these patients are not unconscious, or semi-conscious, or otherwise suffering from any mental impairment, and because of their repetitive exposure to the blood transfusion procedure will become very familiar with the drill; yet none of these hundreds and hundreds of other patients who have gone through thousands and thousands of transfusions across Cayuga Health's various medical units and facilities has ever reported or complained about this type of reckless behavior on the part of any other CMC nurses.

(2) CMC has not received any reports from a concerned staff member about any breaches of protocol in the blood transfusion process other than with the October 2012 Near Miss incident.

(3) No charge nurse, team leader, nursing supervisor, unit manager, or any other supervisor or manager has witnessed and/or reported any such patient safety violations involving the blood transfusion process, nor have they ever reported overhearing nurses talking about any shortcuts being taken in the process due to short staffing or for any other reason. (The only exception to this is Ms. Marshall, a former team leader who first made this claim when speaking in her own defense during the investigation into the complaint by Patient SF, and Michael Doane whose testimony was completely discredited). [17]

[17] Mr. Doane is a former CMC employee who was passed over for a promotion; who stated that he did not get along with the woman who was selected for the promotion; and who went from a manager position to a non-supervisory staff position before leaving CMC. (Tr. 1413-15). Mr. Doane testified that he was not subpoenaed or even contacted by counsel for the General Counsel or counsel for the Union, but rather reached out to them because he wanted to appear and give testimony against CMC. (Tr. 1413-14). When asked if he was literally a former disgruntled employee, Mr. Doane responded by saying he was "unhappy" and "sad" about CMC. (Tr. 1414). On direct examination by counsel for the General Counsel, Mr. Doane claimed that during the time when he was a manager at some point he became aware of nurses not performing the two-nurse bedside verification and that he did not discipline them "beyond verbally". (Tr. 1409). This testimony should be completely rejected. Mr. Doane did not provide any specifics as to who, when or how many times this supposedly happened. If verbal disciplinary warnings were given as he claims, they would be documented and they would have been produced in response to the General Counsel's and Union's subpoenas, yet no such records were offered into evidence because no such records exist. When confronted on cross examination, Mr. Doane did admit that nurses have a responsibility to document in the medical record accurately; that it's a problem if a nurse falsifies a medical record; and that nurses at CMC have a responsibility to follow CMC policy, particularly with respect to high-risk procedures that pose a real danger to a patient in the event of a mistake. (Tr. 1418-19, also at 1445-46). However, he became argumentative and evasive when pressed for specifics about the occasions when nurses under his supposedly falsified patient records with impunity. (Tr. 1422-31). At one point the witness began making all kinds of exaggerated gestures such as shrugging his shoulders and pretending to be writing something down, and waving his hands. (Tr. 1431-32, also at 1433). His testimony deteriorated from there to the point that he basically said ended up saying that he didn't realize at the time what was happening at CMC with respect to how nurses were filling out the Blood Transfusion Cards but when thinking about it "retrospectively" now he realizes they should have initiated and dated any entries when they were filling in a box that that previously mistakenly left blank. (Tr. 1440). Eventually Mr. Doane changed his testimony 180 degrees on by suddenly declaring contrary

(4) Every blood transfusion requires two nurses to perform verifications both outside the patient room and inside the patient room and to document the medical record by filling out and signing a Blood Transfusion Card certifying that all steps were followed. These cards are examined by the Lab following every transfusion, and any anomalies would be immediately reported. CMC has not received any such reports in which the responsible nurses omitted the bedside verification, and CMC is not aware of any instance in which one or both nurses gave a false certification, other than the 9/11/16 incident and the false certification admitted to by Ms. Lamb and Ms. Marshall.

(5) During the investigation into the complaint by Patient SF, CMC's Director of Quality & Patient Safety Karen Ames, along with Assistant Vice President of Patient Services Linda Crumb,

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to his direct testimony that it was his practice as a nurse to falsify medical records. (Tr. 1445-46). Specifically with respect to blood transfusions in which the two-nurse bedside check supposedly was omitted, Mr. Doane could not provide any specifics beyond say "it was not frequently, but it was not infrequently either." (Tr. 1453). Mr. Doane went on to say that he never reported any of these instances to the incident reporting system or to anyone else (Tr. 1453), nor could he provide a good explanation as to why he would ignore such serious breaches of a National Safety Standard and condone endangering patient lives in violation of CMC policy and the ethics of his profession, nor could he explain how he would have known about the failure to conduct the two-nurse bedside check unless he was in the habit of following nurses into patient rooms to monitor what they were doing or not doing. Of course, it is not enough to say that he saw nurses verifying blood at the desk, because ever since CMC policy was amended in early 2013 to add a double tier two-nurse verification, nurses have been required to perform the initial verification at the desk before the blood enters the patient room. Seeing nurses verify blood at the desk begs the question as to whether or not they subsequently conducted a second two-nurse verification at the patient's bedside as set forth in Lippincott and as required by a longstanding National Safety Standard and by CMC longstanding policy (the two-nurse bedside verification had been a fixture in CMC policy since long before the 2013 addition of a mandatory two-nurse desk check). Furthermore, Mr. Doane appeared to be unable in his testimony to be able to distinguish between where nurses fill out the paperwork and where they actually check the necessary patient information and information on the unit of blood, given that his affidavit to the Board only addressed where the nurses completed the paperwork. (Tr. 1462-64). Mr. Doane's testimony proceeded to become hopelessly confusing, until he **finally flatly admitted that in fact during the time he was a manager the two nurse bedside verification did always take place, and that there was never an occasion where blood was hung and administered without two nurses performing the verification at the bedside. (Tr. 1470).**

interviewed six ICU staff nurses including Ms. Lamb and Ms. Marshall. In those investigatory interviews, unlike Ms. Marshall, Ms. Lamb never claimed that there was a practice of skipping the bedside verification process when busy; Ms. Marshall made this claim but was unable to provide any specifics; RN Joan Tregaskis confirmed that she always checks the blood with another RN at bedside but stated that she couldn't speak for other nurses; RN Anita Tourville also confirmed she always does the proper two-nurse bedside check, but although she indicated there "may be" an occasion when it is not, no specifics were provided and her comment appeared to be more speculation than a statement of fact; similarly RN Terry Ellis confirmed that she knows a final bedside check is the required practice and that this is done, but also appeared to speculate in saying that she "can't say that there has **never** been an occurrence when it is done away from bedside such as at the nurses station"; and RN Ananda Szerman initially focused on verifications at the nurses station (which are of course also required by CMC policy), but acknowledged when pressed that verification must also be done at the bedside as stated on the Blood Transfusion Card, and when asked if nurses were documenting something different from what they were actually doing, she said no, thus confirming that the attestations on the

Blood Cards to a two-nurse bedside verification were accurate. Each RN was clear about the policy's requirement for a final two-nursebedside verification, but said they were unable to confirm what everyone else has or hasn't done. In these discussions and in a follow-up safety huddle with the department on October 4, no one was able to provide any hard information about any actual instances in which the two-nurse bedside verification – which is the final and most critical safeguard to protect the life and well-being of the patient – had not been performed prior to starting an infusion. In other words, none of the staff nurses who were spoken to identified any actual instance in which either they themselves or others who they knew about had skipped the two-nurse bedside verification, which is what Ms. Lamb and Ms. Marshall admitted to having done on 9/11/16 thus prompting Patient SF's complaint.

(6) The investigation revealed that Patient SF received a total of 31 transfusions at CMC by dozens of different nurses across several different patient care units, and that in every instance except the transfusion on 9/11/16, all of the other nurses followed the same drill and carried out the final two-nurse bedside verification, including three previous transfusions by ICU nurses during the patient's same hospitalization that were all carried out in accordance with the National Safety Standard and with CMC

policy.

(7) When questioned about the incident, Ms. Marshall insisted that there must be something wrong with the policy, and later was dismissive about the need for a final verification at the bedside without any interruptions or distractions by brazenly asserting that should could handle performing the necessary verifications at the desk while "multi-tasking." Ms. Marshall also contradicted herself during the investigatory meeting by first claiming that she did check the patient's ID bracelet, but subsequently acknowledging that she omitted the bedside verification by stating, "I would have but we were extremely busy and [the other RN] was not available". Ms. Marshall's initial statement to the Director of Quality & Patient Safety that she (Marshall) had checked the patient's ID bracelet was also inconsistent with what she had told Charge Nurse Scott Goldsmith after Patient SF first reported her concern about the reckless transfusion, as well as being inconsistent with Patient SF's accounts given twice verbally to CMC management (which were contemporaneously documented) and once in her own written statement.

From these facts, it is easy to see why CMC relied on the overwhelming evidence gleaned from extensive hospital records and from everyone else (i.e. the patient, the patient's sister who happened to be a critical care nurse, the Charge Nurse, the other ICU nurses, and even Ms. Lamb),

rather than Ms. Marshall's shifting explanations and unsupported claims, in concluding that the policy requiring a final two-nurse verification at the patient's bedside was being following consistently throughout the Medical Center, except in the case of the 9/11/16 transfusion administered by Ms. Lamb and Ms. Marshall.

Furthermore, the overwhelming weight of the credible testimonial evidence provided at the hearing establishes that CMC nurses do in fact follow the National Safety Standard and follow CMC policy with respect to the critical two-nurse bedside verification prior to commencing a blood transfusion. Four staff nurses appeared pursuant to Respondent's subpoena and consistently testified that their own practice, as well as the practice of every other nurse with whom they have participated in a blood product administration, have always scrupulously followed the two-nurse bedside verification requirement, including Nate Newman, Seth Mead, Laurel Rothermel and AJ Barnes; along with a fifth witness Jennifer Cole who was also a staff nurse at all relevant times.[18] Each of these witnesses provided strong and unwavering testimony as to this fact, and nothing on cross examination in any way diminished their credibility. Not only was their testimony clear and internally consistent, but it was consistent with and corroborated by the testimony of one another, as well being consistent with hospital records, including a multitude of Blood Administration Cards as well as the absence of any contrary reports in CMC's incident reporting system. In addition to the staff nurse witnesses, every other witness called by the Respondent in a Charge Nurse position or a Nurse Manager or Nursing Administration position all consistently testified that insofar as they have conducted blood transfusions they never omitted the two-nurse bedside verification, and they had no knowledge and had never received any reports of a case in which this

[18] This testimony by five staff nurses that every other nurse they have ever performed a blood transfusion with has also performed the two-nurse bedside verification sweeps in many dozens of other nurses since blood transfusions happen all the time at CMC and a second nurse is always involved.

was not done (other 9/11/16). All of these witnesses are highly credentialed healthcare professionals whose testimony was forthright and consistent not only internally, but also with one another and with the mountain of documentary evidence.

POINT FIVE:

THE GENERAL COUNSEL'S OTHER ARGUMENTS REPRESENT RED HERRINGS THAT SHOULD BE REJECTED.

The General Counsel has raised various arguments in an effort to muddy the waters and effectively prevent Your Honor from seeing the forest through the trees.

Differences in Witness Accounts in the Patient Room on 9/11/16

One such red herring is the attempt to raise discrepancies over the respective witness accounts of exactly who said what in the patient's room on 9/11/16. From the beginning CMC had no reason whatsoever to doubt the patient's account of what occurred in her room on 9/11/16. Patient SF had no reason to target Ms. Marshall or twist the facts as to what occurred. Nor did CMC have any reason to doubt the account by Patient SF's sister Star York. Again Ms. York had no reason to target Ms. Marshall or twist the facts. Furthermore, the contemporaneous written account by the Charge Nurse Scott Goldsmith as set forth in the incident report is consistent with the accounts provided by the patient and her sister. These three contemporaneous accounts corroborate one another in all material respects. The three witness statements do not match one another word-for-word, because they were each told from their respective individual perspectives/memories. Such minor differences in different witness accounts actually enhance the

credibility and reliability of those accounts because they reflect an honest non-scripted telling by the witnesses of what they individually recall having occurred.

In contrast, Ms. Marshall had every motive to shape her account of what occurred in Patient SF's room on 9/11/16 so as to present her conduct in the most favorable light possible. Not only did Ms. Marshall have the obvious motive to misrepresent the facts, but she has admitted to falsifying the medical record and her story about the 9/11/16 incident shifted several times as revealed in the transcript of her taped investigatory interview.

Scope of CMC's Investigation

The General Counsel will likely argue that the employer's investigation into the 9/11/16 incident was lacking because many staff nurses were not interviewed about their practice with respect to the two-nurse bedside verification. This argument ignores that fact that CMC did speak with several nurses and none of them came forward with a concrete example of even a single instance in which the two-nurse bedside verification was not performed. Since two nurses are always involved in blood product administration, these nurses not only spoke for themselves but for every other nurse who they had ever performed a blood transfusion with. It was not necessary or reasonable to expect that CMC would interview hundreds of nurses about this, particularly since CMC did review many hundreds of nurses' attestations on the Blood Transfusion Cards that they had carried out the two-nurse bedside verification, and since an examination of CMC's Incident Reporting System showed no reports of any failure to perform the two-nurse bedside verification going back as far as October 2012, not to mention that the importance of this critical patient safeguard is taught in Nursing 101, Lippincott, National Saftey Standards, CMC policy and CMC training.

Focus on Existence of Prior Discipline in Other Discharge Cases

As discussed above, CMC has a consistent past history of immediately discharging any nurse or other staff member who it learns has falsified a medical record, as well as having discharged the responsible nurse who hung the wrong blood in the October 2012 incident. In some of these cases, the employees who were discharged also had one or more prior disciplinary actions in their file; however, this does not prove that they would not have been discharged in the absence of such prior disciplines, nor is there any basis for making such an inference since those cases where no prior disciplines existed also resulted in immediate discharge for the falsification. Furthermore, CMC managers testified that falsification of a medical records is always considered grounds for immediate discharge without regard to the employee's prior record because it is unlawful, unethical and inherently dangerous to falsify medical records for obvious reasons.

Draft Termination Letter and Draft Public Statements Pre-Dating Ms. Marshall's October 4 Interview

As discussed above, from the very beginning CMC was immediately confronted with two realities: (1) a serious patient complaint about the intentional violation of a National Safety Standard and a critical patient safeguard in a high-risk medical procedure; and (2) the fact that one of the responsible nurses happened to be a highly vocal union proponent and the subject of previous unfair labor practice charges. As also discussed above, CMC had no reason to doubt the patient's account of what happened, nor the corroborating account from her sister who happened to be a critical care nurse. Furthermore, from early on in the investigation, CMC had the contemporaneous report from the Charge Nurse, as well as Ms. Lamb's admission that she never entered the patient's room despite certifying in the medical record to the two-nurse bedside verification and that she knew it was wrong. CMC was also in the process of examining all of its

records in the blood bank and in the incident reporting system. The only reason it took so long to close the investigation by completing Ms. Marshall's interview was that Ms. Marshall had left on an extended vacation and had not returned any of the telephone voice messages that CMC left for her. In the meantime, CMC already knew that the nature of the offenses warranted immediate discharge, which is why the Human Resources office began to work on draft termination letters; and CMC also knew that the need to discharge Ms. Marshall would almost certainly generate a great deal of controversy both internally and in the local public community, and would almost certainly result in further unfair labor practice charges, which is why the Public Relations office began to work on draft messages in advance of when they would likely be needed.

The argument that the existence of these early drafts undermines the employer's investigation and establishes that the investigation was nothing more than a witch hunt flies in the face of the core undisputed facts at the heart of this case: the discharges resulted from a patient generated complaint that revealed an intentional violation of a National Safety Standard and critical patient safeguard in a high-risk medical procedure, as well as falsification of the medical record.[19]

No Harm No Foul Argument

The General Counsel may attempt to make much of the fact that Patient SF did end up receiving the correct blood on 9/11/16, and thus suffered no harm. First, it is wrong to assert that the patient suffered no harm. Harm is not limited to physical injuries, and the patient's own

[19] Another red herring is material introduced by the General Counsel pertaining to employer statements concerning the Union's organizing campaign. Section 8(c) of the Act provides that, "The expressing of any views, argument, or opinion, or the dissemination thereof, whether in written, printed, graphic, or visual form, **shall not constitute or be evidence of an unfair labor practice** under any of the provisions of this Act [subchapter], if such expression contains no threat of reprisal or force or promise of benefit." (emphasis added).

account makes clear that she was distressed and felt vulnerable in her bed as a result of Ms. Marshall's abrupt, dismissive and patently unsafe behavior with respect to the 9/11/16 blood transfusion. Indeed, although Patient SF sadly became too sick to testify herself by the late stages of the hearing in this case, her sister Star York did testify about the 9/11/16 incident, and she became visibly emotional over the fact that her sister had to suffer additional stress over this incident on top of having to deal with all of the stress caused by her disease.

Second, and more importantly, the severity of Ms. Marshall's conduct was not, and cannot, be judged by the outcome to the patient. The point here is that her behavior exhibited a reckless disregard for patient safety and for this patient's life. Hospitals cannot afford to wait for reckless staff members to kill a patient before taking action.

POINT SIX:

CMC DID NOT VIOLATE SECTION 8(A)(1) WITH RESPECT TO BULLETIN BOARDS OR JOHNNIE'S POULTRY WARNINGS.

In a previous unfair labor practice case, there was evidence of instances in 2015 when one or more supervisors or managers had removed some union postings from one or more open bulletin boards in employee break rooms. However, as a result of these charges, CMC instructed its supervisors and managers not to remove any such material from the bulletin boards where non-work related material is permitted. (Tr. __). Thus, no such union material has been removed from any of the open bulletin boards for employee use within the applicable six month limitations period prior to the charge in this case.

The Amended Complaint asserts that CMC violated Section 8(a)(1) based on a single occasion in July 2016 in which one manager, Director of Patient and Customer Relations

Jacqueline Barr, is alleged to have removed a flyer for a union meeting from a particular bulletin board on which other non-work related materials had been allowed. The only evidence offered by the General Counsel in support of this claim was testimony by Ms. Marshall and a close-up or zoomed-in photograph taken by Ms. Marshall at least a week later purportedly showing the same bulletin board with some non-work related postings, including what appears to be an anti-union posting. (Ex. GC-34).

However, the credible evidence establishes that CMC has always maintained two separate types of bulletin boards throughout the Medical Center. The small fabric bulletin boards adjacent to the time clocks have always been exclusively reserved for official CMC business, including such items as statutory notices to employees, information about employee benefits, and memoranda from senior leadership on various topics (referred to as "reserved bulletin boards"). Other bulletin boards located in break rooms and a public bulletin board near the cafeteria are open for employee use to post non-work related material, such as advertisements for dancing lessons, used cars for sale, apartments for rent, etc., as well as many union-related notices that have been posted and that CMC has allowed to remain (referred to as "open bulleting boards"). (Tr. 2880-84).

Ms. Barr testified that she did remove a union posting from an official bulletin board adjacent to the time clock by the elevator on the 3rd floor, which is a small fabric board reserved exclusively for CMC notices. Ms. Barr testified that Ms. Marshall saw her do this and questioned her right to remove the union flyer, to which Ms. Barr responded that no non-work related materials were allowed on this particular bulletin board since it is used for official CMC notices. (Tr. 2879-83).

Ms. Barr testified that Exhibit R-77 consists of two photographs that she took of the

particular reserved bulletin board by the timeclock and elevator on the 3rd floor, and a third Ms. photograph that she took showing one of the large cork open bulletin boards where employees can post any material, including union-related notices that are not removed. (Tr. 2890-94).

The photograph taken by Ms. Marshall is clearly of a different much larger cork bulletin board. It is not the same reserved bulletin board that Ms. Barr removed a non-work related posting from on the occasion in question in July 2016. Ms. Marshall's photograph appears to show one of the open bulletin boards where non-work related notices are allowed, although the prominent placement of an anti-union notice in Ms. Marshall's photograph suggests that the image may have been staged.[20] Ms. Barr testified that she was absolutely positive that the bulletin board shown in Ex. GC-34 (Marshall's photograph) is not the same bulletin board where she removed an item and was confronted by Ms. Marshall, because the two bulletin boards are made of different material and are a different size. (Tr. 2885-87).

In resolving the discrepancy over which bulletin board was involved in the July 2016 exchange between Ms. Barr and Ms. Marshall, there is no reason to doubt the credibility of Ms. Barr's testimony; yet as already demonstrated above *ad nauseam* Ms. Marshall is not a credible witness. Among many other reasons to doubt Ms. Marshall's credibility are her willingness to falsify a medical record; as well as her shifting excuses for her behavior in the 9/11/16 incident; and her combative, argumentative demeanor when being cross examined. We therefore submit that the General Counsel has failed to carry its burden of proof with respect to this charge.

During the hearing, the General Counsel amended the complaint to add a new charge alleging that when speaking with prospective employee witnesses, CMC violated Section 8(a)(1)

[20] When asked about the "Collective Bullying" flyer shown in Ex. GC-34, Ms. Barr testified that she had never seen that before, even though in the course of her regular duties she moves throughout the building on a daily basis. (Tr. 2887).

by failing to inform them of the necessary *Johnnie's Poultry* warnings. However, each of the Respondent's non-supervisory employee witnesses testified that when they first met with CMC's counsel, he did in fact advise them of the Johnnie Poultry warnings; and they clearly understood that they had no obligation to answer any questions; and that there would be no reprisals of any kind based on what they did or didn't say; and that their decision to proceed with the interview was completely voluntary on their part. (See Tr. 2 514, 2523-27, 2528-31, 2761-63, 2777-79, 2794-95). Accordingly, this charge should likewise be dismissed.

SUMMARY AND CONCLUSION

On September 11, 2016, Ms. Marshall and Ms. Lamb admittedly engaging in the willful violation of Medical Center policy and a National Safety Standard, thus needlessly endangering the life of Patient SF and placing her in fear. In addition, both nurses falsified the medical record which has always been grounds for immediate discharge at Cayuga Medical Center (and in virtually every other hospital and healthcare facility in America). Ms. Marshall disregarded the patient's expressed concern by proceeding with the blood transfusion without following safety protocols. Neither Ms. Marshall's shifting explanations nor the General Counsel's misplaced arguments can override these core facts. CMC was well aware of Ms. Marshall's protected activity, but that had no bearing on the investigation into a patient generated complaint or on the disciplinary outcome. The outcome for such gross misconduct by professional registered nurses would have been the same even if there was no union or other protected activity.[21]

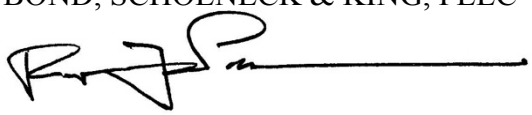
[21] The General Counsel cannot establish a case of retaliation under the Board's *Wright Line* standard, which requires: (i) the existence of protected activity; (ii) that the employer knew of the protected activity; and (iii) an adverse employment action. *American Garden Management Co.*, 338 NLRB 644, 645 (2002); *Wright Line*, 251 NLRB 1083 (1980). As for Ms. Lamb, none of the decision-makers involved had any knowledge of her alleged union and/or protected activity, and therefore, they were clearly not motivated by it. Wearing a button with a World War II icon and no reference to the union does not represent a public declaration of union support. (Tr. 1526-30). *See,e.g., C &*

For the reasons stated above, Cayuga Medical Center respectfully requests that the Amended Complaint be dismissed in its entirety. The undersigned counsel hereby certifies that a copy of the foregoing Post-Hearing Brief is being served in accordance with the Board's Rules upon Counsel for the Union, Mimi Satter.

Dated: May 26, 2017

Respectfully submitted,

BOND, SCHOENECK & KING, PLLC



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S Distributors, 321 NLRB 404, 407 (1996) (affirming ALJ decision where decision-makers must have actual knowledge of protected activity and/or be the ones who harbored anti-union animus to establish a prima facie case of retaliation). Additionally, as applied to both nurses, under *Wright Line*, there is no liability if the employer's adverse employment action would have been taken even in the absence of protected activity. Here, despite the General Counsel's assertions, it is clear that the terminations were warranted and these decisions would have been made regardless of any alleged protected activity.